



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR DISEASE CONTROL AND ENVIRONMENTAL EPIDEMIOLOGY

RECORD OF INVESTIGATION OF ENTERIC ILLNESS

FOR PUBLIC HEALTH AGENCY USE ONLY

CONDITION I.D.

DATE RECEIVED BY LPHA

NAME (LAST, FIRST, M.I.)

DATE OF BIRTH

AGE

SEX

☐ Male ☐ Female

RACE

ADDRESS

CITY, STATE, ZIP CODE

COUNTY

CONDITION NAME

TELEPHONE

2ND TELEPHONE

SYMPTOMS

SYMPTOM	YES	NO	ONSET DATE/TIME	SYMPTOM	YES	NO	ONSET DATE/TIME	SYMPTOM	YES	NO	ONSET DATE/TIME
ASYMPTOMATIC	<input type="checkbox"/>	<input type="checkbox"/>		NAUSEA	<input type="checkbox"/>	<input type="checkbox"/>		MUSCLE ACHES	<input type="checkbox"/>	<input type="checkbox"/>	
DIARRHEA*	<input type="checkbox"/>	<input type="checkbox"/>		ABDOMINAL CRAMPS/PAIN	<input type="checkbox"/>	<input type="checkbox"/>		HEADACHE	<input type="checkbox"/>	<input type="checkbox"/>	
WATERY DIARRHEA*	<input type="checkbox"/>	<input type="checkbox"/>		FEVER _____°	<input type="checkbox"/>	<input type="checkbox"/>		DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY DIARRHEA*	<input type="checkbox"/>	<input type="checkbox"/>		CHILLS	<input type="checkbox"/>	<input type="checkbox"/>		JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	
≥3 LOOSE STOOLS IN 24 HOURS*	<input type="checkbox"/>	<input type="checkbox"/>		BODY ACHES	<input type="checkbox"/>	<input type="checkbox"/>		URINARY TRACT INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	
VOMITING*	<input type="checkbox"/>	<input type="checkbox"/>		FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>		OTHER:			
OTHER:				OTHER:				OTHER:			
<input type="checkbox"/> STILL SYMPTOMATIC <input type="checkbox"/> RECOVERED <input type="checkbox"/> DIED				DATE SYMPTOMS RESOLVED:				DURATION OF ILLNESS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS			

*EXCLUDE FROM HIGH RISK DUTIES

TREATMENTS

DRUG	DATE	DOSAGE	FREQUENCY	DURATION

BACKGROUND INFORMATION

HIGH RISK EMPLOYMENT							
PATIENT	YES	NO	UNK	HOUSEHOLD MEMBER(S)	YES	NO	UNK
FOODHANDLER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOODHANDLER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASSOCIATED WITH OR ATTENDS A CHILD/ADULT CARE CENTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASSOCIATED WITH OR ATTENDS A CHILD/ADULT CARE CENTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEALTHCARE WORKER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEALTHCARE WORKER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCCUPATION	PLACE OF EMPLOYMENT (INCLUDE ADDRESS)	DATE(S) WORKED PRIOR TO ONSET AND DURING ILLNESS	EXCLUDED FROM WORK	EXCLUDED FROM HIGH RISK DUTIES			
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			
			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			

TRAVEL(S)

DATE	PATIENT OR HOUSEHOLD MEMBER	LOCATION (CITY, STATE, COUNTRY)	REASON FOR TRAVEL (VISIT PERSONS, ATTEND GROUP FUNCTION, ETC.) BE AS SPECIFIC AS POSSIBLE

ANIMAL EXPOSURE

DATE	TYPE (PET, VISIT TO ZOO, FARM)	ANIMAL	EXPOSURE			ANIMAL ILL?			LOCATION (CITY, STATE, COUNTRY)
			DAILY	LIMITED	ONE TIME	YES	NO	UNK	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COMMENTS ON QUESTIONS ABOVE:

FOOD EXPOSURE	FOOD EXPOSURE			TYPE		DATE		NAME			LOCATION (CITY, STATE, COUNTRY)													
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
	<input type="checkbox"/> GROCERY <input type="checkbox"/> RESTAURANT <input type="checkbox"/> OTHER																							
OTHER FOODS	TYPE OF FOOD		YES NO	SPECIFIC FOOD	DATE	TYPE OF FOOD		YES NO	SPECIFIC FOOD	DATE	TYPE OF FOOD		YES NO	SPECIFIC FOOD	DATE									
	UNPASTEURIZED DAIRY		<input type="checkbox"/> <input type="checkbox"/>			GROUND BEEF (RAW OR UNDERCOOKED)		<input type="checkbox"/> <input type="checkbox"/>			POULTRY (RAW OR UNDERCOOKED)		<input type="checkbox"/> <input type="checkbox"/>											
	HOME-CANNED FOODS		<input type="checkbox"/> <input type="checkbox"/>			SEAFOOD (COOKED)		<input type="checkbox"/> <input type="checkbox"/>			HUNTED OR TRAPPED MEAT		<input type="checkbox"/> <input type="checkbox"/>											
	EGGS (RAW OR UNDERCOOKED)		<input type="checkbox"/> <input type="checkbox"/>			SEAFOOD (RAW)		<input type="checkbox"/> <input type="checkbox"/>			ETHNIC		<input type="checkbox"/> <input type="checkbox"/>											
	OTHER					OTHER					OTHER													
	OTHER FOODS COMMENTS:																							
WATER & SEWAGE	SEWAGE SYSTEM AND WATER SUPPLY				IF PRIVATE, TYPE					IF PUBLIC, TYPE														
	HOME SEWAGE SYSTEM <input type="checkbox"/> PRIVATE <input type="checkbox"/> PUBLIC <input type="checkbox"/> BOTH <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE				<input type="checkbox"/> LAGOON <input type="checkbox"/> SEPTIC TANK <input type="checkbox"/> SAND MOUND <input type="checkbox"/> AEROBIC TREATMENT UNIT (ATU) <input type="checkbox"/> HOLDING TANK <input type="checkbox"/> CONSTRUCTED WETLAND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (SPECIFY)					<input type="checkbox"/> LAGOON <input type="checkbox"/> SEWAGE TREATMENT PLANT <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER (SPECIFY)														
	HOME WATER SUPPLY <input type="checkbox"/> PRIVATE <input type="checkbox"/> PUBLIC <input type="checkbox"/> BOTH <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NONE				<input type="checkbox"/> WELL <input type="checkbox"/> CISTERN <input type="checkbox"/> POND <input type="checkbox"/> LAKE <input type="checkbox"/> RIVER <input type="checkbox"/> BOTTLED <input type="checkbox"/> SPRING <input type="checkbox"/> OTHER (SPECIFY)					PUBLIC SEWAGE - NAME AND LOCATION														
										PUBLIC WATER - NAME AND LOCATION														
	RECREATIONAL WATER																							
	DATE(S)		TYPE OF RECREATIONAL WATER EXPOSURE			LOCATION (BE SPECIFIC)			DATE(S)		TYPE OF RECREATIONAL WATER EXPOSURE			LOCATION (BE SPECIFIC)										
ILL CONTACTS	NAME AND ADDRESS				DATE OF BIRTH/AGE	SEX	RELATION TO CASE	SIMILAR ILLNESS		ONSET DATE	LAB TESTING				EPI-LINKED, CD-1, ENTERIC FORM COMPLETED*									
								YES	NO		POS	NEG	NOT DONE	UNK	YES	NO								
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
								<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
*LIST HOUSEHOLD AND OTHER CLOSE CONTACTS WITH SIMILAR ILLNESS. COMPLETE SEPARATE "CD-1 DISEASE CASE REPORT" AND "RECORD OF INVESTIGATION OF ENTERIC ILLNESS" FOR EACH ILL CONTACT.																								
OTHER FACTORS	MEDICAL AND SOCIAL FACTORS																							
	<input type="checkbox"/> ALCOHOLISM				<input type="checkbox"/> DIABETES				<input type="checkbox"/> FOOD ALLERGIES				<input type="checkbox"/> PEPTIC ULCER				<input type="checkbox"/> GASTRIC SURGERY				<input type="checkbox"/> CARDIOVASCULAR DISEASE			
	<input type="checkbox"/> HEMATOLOGIC DISEASE				<input type="checkbox"/> IMMUNE DEFICIENCY				<input type="checkbox"/> LIVER DISEASE				<input type="checkbox"/> CANCER				<input type="checkbox"/> KIDNEY DISEASE							
	MEDICATIONS																							
	<input type="checkbox"/> ANTIBIOTICS				<input type="checkbox"/> CHEMOTHERAPY				<input type="checkbox"/> RADIOTHERAPY				<input type="checkbox"/> SYSTEMIC STEROIDS				<input type="checkbox"/> IMMUNOSUPPRESSANTS				<input type="checkbox"/> ANTACIDS			
OTHER FACTORS COMMENTS:																								
POSSIBLE SOURCE	SOURCE OF INFECTION (SUSPECTED/POSSIBLE) (FOOD, WATER, TRAVEL, PERSON TO PERSON, ETC.)										REASON (CASE REPORT, EPIDEMIOLOGICAL INVESTIGATION, MULTIPLE CASE REPORTS, LABORATORY TESTING)													
	OUTBREAK RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN					OUTBREAK COMMENTS:																		
OTHER PERTINENT EPIDEMIOLOGICAL DATA OR COMMENTS:																								
NAME OF INVESTIGATOR														DATE COMPLETED										